Home Visit and Service Observation Form

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Form Instructions

This form shall be completed and signed for each home visit and service observation visit. Record notes in the section provided during home visits and service observations, and provide detailed documentation of the home visit/service observation in the Electronic Medicaid Waiver System (EMWS). This form shall be uploaded in EMWS to provide verification that a home visit/service observation occurred.

Participant Name: _____

Case Manager Name: _____

Case Management Agency: _____ **N/A** ☐

Case Manager Signature: _____ **Date:** _____

Monthly Home Visit Verification

Date		Start Time		End Time	

The participant, legally authorized representative, or provider representative shall select the topics discussed during the home visit. Case managers are not required to address every topic at each home visit.

☐ Questions and concerns

☐ Participant rights (including current restrictions and possible violations)

☐ Health and welfare

☐ Choice of providers and services (including the need for new or additional)

☐ Satisfaction with services

☐ Satisfaction with providers

Participant/Legally Authorized Representative Name: _____ Date: _____

Participant/Legally Authorized Representative Signature: _____

If the participant or legally authorized representative is not able to sign, the provider/provider staff shall sign off on the home visit.

Provider/Provider Staff Printed Name: _____

Provider/Provider Staff Signature: _____ Date: _____

Notes *(Attach additional pages if more space is needed)*

Participant Name: _____

Use Service Observation Verification fields below as required. Attach additional pages if more space is needed.

Service Observation Verification

Date		Start Time		End Time	
Service Observed		Provider			

The provider representative shall select the topics discussed during the service observation.

☐ Training objective/goal progress ☐ Potential changes to the IPC ☐ Level of support

Provider/Provider Staff Printed Name: _____

Provider/Provider Staff Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

Service Observation Verification

Date		Start Time		End Time	
Service Observed		Provider			

The provider representative shall select the topics discussed during the service observation.

☐ Training objective/goal progress ☐ Potential changes to the IPC ☐ Level of support

Provider/Provider Staff Printed Name: _____

Provider/Provider Staff Signature: _____Date: _____

Case Manager Signature: _____ Date: _____

Notes *(Attach additional pages if more space is needed)*